AMERICANS WITH DISABILITIES ACT GRIEVANCE FORM

Name: _____ **Home phone:** _____

Address: _____ **Cell phone:** _____

_____ **Business phone:** _____

Date incident occurred: _____

Miami-Dade County department name and address where incident occurred:

Department name: _____

Incident address: _____

_____

Please state the name, phone number and address of anyone with the related department you have contacted about your grievance as well as the date of the contact:

Name: _____ **Phone number:** _____

Address: _____ **Contact date:** _____

Describe grievance, including specific names, dates and locations. Attach more sheets if necessary.

_____

_____

_____

_____

Explain why you feel you have been discriminated against on the basis of your disability:

_____

_____

_____

_____

_____ _____

Signature of Complainant **Date Completed**

Mail completed form or send via email to:

Office of ADA Coordination
111 NW 1st Street, 10th Floor, Suite 1035
Miami, Florida 33128
adaoffice@miamidade.gov

To obtain this form in an alternative format, please call 305-375-3566 or send an email to adaoffice@miamidade.gov.

Rev. Date: 5/11